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ENGAGING TRADITIONAL LEADERS AS CHANGE AGENTS FOR HEALTH: Strategies, Lessons and Recommendations

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The Zambia Integrated Systems Strengthening Program (ZISSP) is a technical assistance program to support the Government of Zambia. ZISSP is managed by Abt Associates, Inc. in collaboration with American College of Nurse-Midwives, Akros Research Inc., Banyan Global, Johns Hopkins Bloomberg School of Public Health-Center for Communication Programs, Liverpool School of Tropical Medicine, Broad Reach Institute for Training and Education and Planned Parenthood Association of Zambia. The project is funded by the United States Agency for International Development, under contract GHH-I-00-07-00003. Order No.GHS-I-11-07-00003-00.

Acronyms

CBO	Community Based Organisation
CBV	Community Based Volunteer
CHC	Community Health Coordinator
CHW	Community Health Workers
DHMT	District Health Management Team
MCDMCH	Ministry of Community Development Mother and Child Health
MOH	Ministry of Health
NHC	Neighbourhood Health Committee
SMAG	Safe Motherhood Action Group
ZISSP	Zambia Integrated Systems Strengthening Program
USAID	United States Agency for International Development

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1.0 Background

The Zambia Integrated Systems Strengthening Program (ZISSP) has worked closely with the Ministry of Health (MOH) and Ministry of Community Development Mother and Child Health (MCDMCH) since 2010 to strengthen skills and systems to increase access to and uptake of health services. As part of these initiatives, ZISSP has engaged communities in health planning, trained behaviour change advocates in communities, and supported delivery of health services within communities. The program, which is funded by the United States Agency for International Development (USAID), works in 27 target districts and focuses on health services related to HIV and AIDS, family planning, maternal and neonatal health, child health and nutrition, and malaria.

ZISSP has seconded Community Health Coordinators (CHCs) in ten provinces to support the MCDMCH with capacity-building and technical support supervision for community health systems strengthening. CHCs coordinate ZISSP provincial, district and community-level activities, working closely with the District Health Management Teams (DHMT) and health facilities. Within communities, CHCs work closely with Neighbourhood Health Committees (NHCs) and community-based volunteers (CBV) to conduct community health mobilisation activities. Relationships have also been created with traditional leaders (such as chiefs and headmen) and other community leaders (e.g. teachers, church leaders, local government officials) to engage them in community health initiatives.

Each CHC is responsible for monitoring community health activities and documenting processes and outcomes on a Quarterly basis. The reports are based on activities at community level within the ZISSP health centre catchment areas. The reports are submitted to ZISSP main office in Lusaka, where they are consolidated into quarterly reports for submission to USAID.

A recurring theme across the CHC reports is the engagement of traditional and other community leaders to increase uptake of health services and healthy behaviours. Using traditional leaders as agents of change is not a new concept. However, analysis of how to engage traditional leaders and the results of this interaction are not well-documented in Zambia. A better understanding of strategies and lessons learned can guide government and programs to plan how the health system can partner with these leaders in community health initiatives.

1.1 Purpose of the Report

The purpose of this report is to examine how traditional leaders have been used as agents of change in community health under ZISSP-supported programming and to make recommendations to guide future community health programming.

1.2 Objectives

1. To discuss the types of health-related activities that involved traditional leaders.
2. To discuss the results of engaging traditional leaders.
3. To identify key lessons learned and challenges faced in engaging traditional leaders in health.
4. To generate recommendations that can strengthen the role of traditional leaders as change agents.

1.3 Methodology

The methodology used two main approaches: review of CHC activity reports and in-depth interviews with CHCs. The review covered the time period (January, 2011) to (December, 2012).

In total, six CHC activity reports were reviewed which discussed community-level activities in Chongwe District (Lusaka Province), Chilubi District (Northern Province), Kalomo District (Southern Province), Kabwe District (Central Province) and Shangombo and Lukulu Districts (Western Province). In general, each of the six reports was based on a specific field trip that occurred between (January, 2011) to (December, 2012). In order to systematically review the qualitative reports, an observation matrix was developed.

To further understand how traditional leaders were engaged in community mobilisation, in-depth interviews were conducted with four of the six CHCs who had submitted the field trip reports. The interviews were not structured

Limitations:

- The reports do not cover approaches used by CHCs to initially engage traditional leaders (e.g. community visits to a Chief's palace, etc.)
- The reports are limited to a specific time period and do not reflect activities occurring throughout the year that may have involved traditional leaders.
- The reports are limited to events supported by ZISSP.
- The information only covers six districts out of five provinces, and therefore is not representative of all geographical areas and traditional leaders of Zambia.
- Views of traditional leaders and government officials were not gathered for the report.

- Quantitative health outcomes cannot be directly attributed to the involvement of traditional leaders.
- There is no consistency in the way community mobilization meetings are planned and conducted.

2.0 Objective 1: Types Of Health-Related Activities which Involve Traditional Leaders

2.1 Traditional leaders as recipients of capacity-building: The majority of CHCs affirmed that they have trained some traditional leaders in capacity-building skills, including how to plan and implement community health activities, and provided training on specific health topics (HIV, malaria, gender and safe motherhood). In some cases, traditional leaders received this training because they are members of the NHC or members of a Safe Motherhood Action Group (SMAG).

2.2 Traditional leaders supporting formation of health committees: The Zambian health system relies on a variety of community-level groups and committees to bring health services closer to the people. The most prominent structure, Neighbourhood Health Committees, represents their community's health needs and is responsible for linkages between their community and the nearest health facility. It is important that NHC members are people who are trusted by the community to carry out this responsibility. Using traditional leaders in the process of identifying NHC members can ensure that an appropriate person is selected for the NHC. Rather than forming NHCs by the health facility staff, the selection of NHC members is done through a community meeting organised by the village headman. The role of the CHC is simply to explain the roles of NHCs so that the leaders and the community members understand. This information is further reinforced by the village headmen, who open the meeting and explain how the community will choose NHC members. The same procedure is used when selecting members of other community-level health committees, such as SMAGs.

2.3 Traditional leaders as actors in community health planning: The Zambian health system uses a bottom-up structure for the development of annual health plans, starting with the community planning process. The NHCs use Participatory Rural Appraisal methods to develop the joint community action plan, identifying health problems that are prevalent in the community and working together with the community members to identify possible solutions to those problems. Traditional leaders are important actors in this process.

2.4 Involvement of Traditional leaders in Stakeholder Meetings: As part of their coordination role, CHCs convene district-level and community-level stakeholders' meetings to ensure buy-in and shared responsibility in planning and mobilising communities for health services.

For instance, CHCs held district-level stakeholders meetings in each ZISSP target district to prepare for the measles campaign week. In addition to traditional leaders, other stakeholders included Members of Parliament, Zambia Police, District Medical Officers, District AIDS Coordinators, and representatives from MCDMCH, churches and community radio stations. The meeting developed a common understanding of the campaign's aim, and participants came up with action plans specifying specific roles for stakeholders during the campaign. Responsibilities of traditional leaders included:

- Headmen to hold village meetings before the campaign and announce dates and places for vaccinations.
- Headmen to ensure that all the eligible children for the campaign in their villages go for measles vaccinations and put punitive measures for defaulters.
- Headmen to support NHCs in their villages through community planning for events.

Photo 1: Participants, including traditional Leaders, attending a health-related stakeholders meeting in Chilubi District.

- Participants to the meeting were encouraged by the chiefs representative's to inform men or husbands to assist in bringing the children to vaccination centres during the week of the campaign.

2.5 Traditional Leaders as community mobilizers for health: At community level, CHCs supported health facilities to engage traditional leaders (headmen and chief's assistants) and other community-level stakeholders to plan for community mobilisation and sensitization on community health events and campaigns (e.g. Child Health Week). The CHCs used the meetings as an opportunity to discuss the causes, transmission and prevention of specific diseases and illnesses in their communities. CHCs also conducted open discussions with community leaders on the challenges faced in service delivery, the importance of coordination at community level and strategies for reaching campaign targets.

At these meetings, traditional leaders informed stakeholders about the best ways to implement social mobilisation activities in their communities. The community sensitisation

meetings identified clear roles of each stakeholder, including traditional leaders. For example, roles included the linkage of leaders to the NHCs, the responsibility of chiefs to mandate meetings with other indunas (chief's representatives) to reach all villages, and the shared responsibility for community sensitisation.

2.6 Traditional leaders as actors in the referral system: Data gathered through CHC reports and interviews has shown that traditional leaders are an integral part of a referral system for services. If traditional leaders are sensitised to health issues, they can play a key role in encouraging people to identify problems in their catchment area and present them during NHC meetings. Traditional leaders can also be linked to other community health structures, such as SMAG and CHWs, for referral of community members with suspected health problems. When solutions cannot be found within the community, the issues can be referred to the health facility.

3.0 Objective 2: Results of Engaging Traditional Leaders

Engaging traditional leaders in community health activities influences two categories of results: systems-level results and health/behavioural-level results.

3.1 Systems-Level Results:

Application of health knowledge and skills: Increased knowledge of specific health issues empowers traditional leaders to take a lead role in community mobilisation. For example, through district-level meetings, the traditional leaders developed a common understanding on the importance of childhood immunization and were able to disseminate consistent messages to their communities around the district. In cases where traditional leaders were members of a health committee (e.g. SMAG, NHC), they use their skills directly for the betterment of their communities.

Health committee formation: The engagement of traditional leaders during formation of the NHCs can have two positive results. First, the NHC member selected receives the blessings of the headman. Second, in some cases the village headman himself is selected by the community to be part of the committee.

> ***"The village headmen who are part of these community groups in their villages are doing a very good job because they are very supportive and they understand whenever you approach them. It is different if the village head doesn't know much of what is happening in areas of health,….in fact others would even demand to say why not involve us and train us because we don't know much of what is happening."***
>
> - **Solwezi CHC**

Ownership of action plans: Involving traditional leaders in community mobilisation was an entry point to engage traditional leaders in developing community health action plans for their communities. Traditional leaders saw value in planning rather than doing unplanned activities.

Coordination with stakeholders: Identification of joint plans specifying clear roles for each stakeholder, including traditional leaders, produced the intended results of coordinated mobilization for uptake of the health services during health events and campaigns. Stakeholders identified appropriate social mobilisation approaches for their communities, including village meetings, door-to-door campaigns, reaching clients during under-five clinic, disseminating information through pupils and teachers at schools, using the church to share information, and the use of drama performances.

The key change factor was the recognition by districts that the authority held by traditional leaders can influence community members to uptake health services, and traditional leaders have existing structures to mobilize communities. When the districts involved traditional leaders in stakeholder meetings, this action further promoted strengthened community-level linkages between traditional structures and health structures. Traditional leaders expressed happiness and readiness to be engaged as change agents during social mobilisation. For example, Chief's representatives pledged to support the Rural Health Centres and NHCs during the sensitization and implementation of Child Health Week.

Photo 2: Community participation during a social mobilization activity.

"The participants [at the Community Sensitization Meeting] were happy with the approach for promoting health in the communities by involving traditional leaders and other opinion leaders. They emphasized that this gesture should continue, and not only to end with the measles and Child Health Week campaigns, but continue in all upcoming national health events. They indicated that traditional leaders were in most cases left out in health service delivery, particularly in such events as the Child Health Week."

- **Interview with CHC**

3.2 Health/Behavioural-Level Results:

Reduction in mortality: Areas where traditional leaders have been fully engaged in community health report a reduced number of maternal deaths. For example, the Acting Principal Nursing Officer Reproductive Health and MNCH in Solwezi District recognizes the involvement of traditional leaders (such as Chief Mumena) as a key factor contributing to recorded reduced number of maternal deaths at health facilities in the district. In this district, traditional leaders have been proactive and attentive to reproductive health issues.

Reduction in traditional practices that negatively impact health: In the ZISSP target districts, traditional leaders are addressing cultural practices that put community members at higher risk of health problems. For example, leaders are discouraging early marriages and gender-based violence by instituting punishment for the offenders. In these areas, cases of early marriages and gender-based violence have reduced.

Increase in referrals: Engaging traditional leaders created wiliness for playing a more active role in health in their communities. Traditional leaders shared that they would work through Community Health Workers to refer suspected measles cases to the health facilities in their communities.

4.0 Objective 3: Lessons learned and challenges

4.1 Lessons Learned

- Coordination and engagement of community actors, including traditional leaders, in district- and community-level planning results in ease of mobilization of communities for increased uptake of health services.

- Where traditional leaders have been meaningfully involved in community programs, the communities produce improved health outcomes, such as increased uptake of health services and reduced maternal mortality.

- Traditional leaders hold respected authority and influence over their subjects and can use their influence for better health outcomes. In order to influence health, the leaders need accurate and correct information on health-related issues. Traditional leaders who have been sensitized on specific health issues have more knowledge than leaders that have not been sensitized, and therefore are better able to mobilize communities for uptake of services.

- Linking traditional leaders, NHCs and health facilities with an effective referral system can result in increased community uptake of services.

- Effective community mobilization requires engagement of all stakeholders, recognizing their comparative advantages in reaching different geographic or population sub-sets of a community. Involvement of traditional leaders is essential, as they have power to demand behaviors or actions from subjects and they understand what works best (and what does not work) in their respective communities.

- Traditional leaders are a cornerstone for community involvement in the planning and implementation of health activities.

4.2 Challenges

Cultural Barriers to Change: Behaviour change often challenges ingrained cultural and traditional beliefs. Engaging traditional leaders in behaviour change in their communities may first require a change in the leader's own personal beliefs, attitudes and practices (e.g. if the leader adheres to harmful cultural practices).

Changing a cultural practice also requires sufficient time to implement a persistent process of action. For instance, culturally-defined gender roles have been inculcated into people over a long period of time. The traditional leader will need sufficient time to get certain messages across, and will also need factual information and persuasive approaches to change community behaviours.

Low access to health education among traditional leaders: Some traditional leaders have not had the opportunity to receive health education, and therefore hold different myths and misconceptions about health issues. In general, there are low levels of knowledge on sexual and reproductive health, HIV and malaria among the traditional leaders. There is also a lack of information, education and communication materials for traditional leaders: Although they have been a number of trainings and materials designed for community mobilisers (e.g. caregivers, NHC members), there are few (if any) materials specifically designed and tailored to the need of the traditional leaders.

Accessibility: Sometimes certain villages are very far, which creates a problem with traveling to see traditional leaders (or vice versa. Traditional leaders may also have difficulties with participating in stakeholder meetings due to distance).

Expectations from traditional leaders: Engaging traditional leaders in health activities follows cultural norms, which could include the provision of gifts for the leaders and, in some cases, for their entourages.

5.0 Objective 4: Recommendations

1. **Target traditional leaders with health education:** Strengthen the capacity of traditional leaders to understand various aspects of health and health services and dispel misconceptions and myths. Reinforce health messages by developing integrated reference materials that are tailored to the needs of the traditional leaders. For ease of use, these materials should include pictures and be written in local languages.

2. **Discuss cultural barriers to change with traditional leaders:** Strategise how traditional leaders can address harmful cultural practices, particularly those that inhibit uptake of HIV, malaria, gender-based violence and TB services.

3. **Promote inclusion of traditional leaders in stakeholder meetings:** Health facility in-charges and DHMTs should be sensitised to recognise the role that traditional leaders can play in mobilising communities for health services.

4. **Continue joint planning processes:** Strengthen long-term joint district planning that involves traditional leaders and NHCs, rather than only involving them on activity- or event-specific planning.

5. **Encourage linkages between traditional leaders and NHCs:** Strengthen the capacity of NHCs to use traditional structures to scale up sensitization activities.